DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28104

FILED SEP 10 1941

Registration District No. 12R13

Primary Registration District No. 3014

Registrar's No. 240

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1300 Moreau Drive
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution
(Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole

(c) City or town Jefferson City, Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. 1300 Moreau Drive
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Martha Frances Clarke

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex female

5. Color or race white

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife H.W.Clarke

6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 25 (Day) 1850 (Year)

8. AGE: Years 91 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Owen County, Kentucky
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business

FATHER
12. Name Barnard Van Daren
13. Birthplace Kentucky
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Frances Riley
15. Birthplace Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Callie Dealin.
(b) Address Jefferson City, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-20-1941 (Month) (Day) (Year)
(c) Place: burial or cremation River View Cemetery

18. (a) Signature of funeral director Floyd Gordon
(b) Address Jefferson City, Missouri

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18
year 1941 hour 7. minute A. M.

21. I hereby certify that I attended the deceased from August 4, 1941, to August 16, 1941; that I last saw her alive on 8-16-, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	14 days.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	PHYSICIAN
Of autopsy	Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Maynard Enloe (M. D. or other)
Address Jefferson City Mo Date signed 9/10/41

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed. Thos. J. Gordon

Licensed Embalmer No. 786

P. O. Address. Jefferson City Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28104

Registration District No. 213 Primary Registration District No. 3014 Registrar's No. 240

1. PLACE OF DEATH:
(a) County Cole
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Martha F. Clarke
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August 18
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death (Pneumonia	
Broncheal	
Due to	
Due to 101	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

No. 2B
-8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28104

Registration District No. 813 Primary Registration District No. 3014 Registrar's No. 240

1. PLACE OF DEATH
(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 50 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Martha F. Clarke
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 8-19-41 (Date received local registrar) (b) Ronna Richter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
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(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY